LEGISLATIVE SERVICES AGENCY
OFFICE OF FISCAL AND MANAGEMENT ANALYSIS

301 State House
(317)232-9855

ADMINISTRATIVE RULE
FISCAL IMPACT STATEMENT

PROPOSED RULE: 02-140 **DATE PREPARED:** Aug 15, 2002
STATE AGENCY: Office of the Sec. of Family and Social Services **DATE RECEIVED:** Jul 8, 2002

FISCAL ANALYST: Alan Gossard
PHONE NUMBER: 233-3546

Digest of Proposed Rule: This rule amends 405 IAC 5-14-2, 405 IAC 5-14-3, 405 IAC 5-14-4, and 405 IAC 5-14-6 to limit the comprehensive or extensive visits for recipients to two per year, and updates the rule to reflect current operating procedures.

The rule also adds 405 IAC 5-14-2.5 to add copayments for dental services ranging from $0.50 to $3.00 per visit to the dentist's office. Copayments cannot be placed on recipients under 18 years of age, on pregnant women, on emergency services, or on institutionalized recipients. The schedule for copayments is $0.50 for a paid service of $10.00 or less, $1.00 for a paid service from $10.01 to $25.00, $2 for a paid service from $25.01 to $50.00, and $3.00 for a paid service of greater than $50.00.

Governmental Entities: *State Impact:* The estimated annualized expenditure reduction for both provisions, including both state and federal shares, is about $831,000. The state share represents 38%, or about $316,000 in reduced General Fund expenditures. Assuming a mid-December implementation date, the FY 2003 total expenditure reduction is estimated to be $450,000, with a state share of about $171,000 in reduced General Fund expenditures.

This rule places no unfunded mandates upon state government.

Background: Of the total annualized expenditure reduction of $831,000, the copayment provision accounts for $796,000, or approximately 95.8%. This estimate is a conservative estimate in that it does not factor in reductions in utilization that might occur due to the copay requirement. The service limitation provision accounts for about $35,000, or 4.2% of the total.

Local Impact: Local governmental agencies that provide Medicaid-funded dental services, such as county dental health clinics, may experience a decrease in payments for dental services to the extent that copayments are not collected. However, since participation in the Medicaid program is optional, this rule places no unfunded mandates upon any local government unit.

Regulated Entities: The annualized impact on dental providers participating in the Medicaid program may range up to $831,000, depending upon the ability of providers to collect copayments from Medicaid recipients and to the extent that individual Medicaid recipients have already had two comprehensive or diagnostic exams during the preceding 12 months.

The program expenditure reduction from copayments is realized by the state in reduced reimbursement to providers in the amount of the copayment. To the extent that copayments are collected from recipients by providers, providers will not have their total reimbursement reduced. However, providers cannot refuse services to recipients who indicate that they are unable to pay the copayment. Providers can, however, attempt to collect any delinquent copayment amount from Medicaid recipients in the same manner that the provider collects delinquent accounts from private pay customers.

There are approximately 1,155 non-pediatric dentists actively participating in the Medicaid program and providing dental services to patients who are subject to these provisions.

Information Sources: Maureen Bartolo, Office of Medicaid Policy and Planning, 232-1165.